NC Medicaid Provider Enrollment
CSC EVC Center

P. O. Box 300020
Raleigh, NC 27622-8020

For certified /overnight mail only:
2610 Wycliff Road, Suite 102
Raleigh, NC 27607-3073

Thank you for your interest in providing additional services as a Community Alternatives Program (CAP) provider with the N.C. Medicaid Program. In order for us to complete the process, please submit the following:

Group Applicant

☐ Community Alternatives Program Addendum to Add Services.
Note: The name on addendum must exactly match the name on original Medicaid Participation Agreement.

☐ Copy of Notification of Endorsement Action by the Local Management Entity or CAP/MR-DD Letter of Attestation, whichever is applicable.

☐ Attachment C - Letter of Attestation for False Claims Act Education.
Note: The Letter of Attestation for False Claims Act Education is required for all providers.

☐ Provider completes and signs the addendum and returns along with the required credentials to:

For USPS Mail:
NC Medicaid Provider Enrollment
Attn: CSC EVC Center
P.O. Box 300020
Raleigh, NC 27622-8020

For Certified/Overnight Mail Only:
NC Medicaid Provider Enrollment
Attn: CSC EVC Center
2610 Wycliff Road, Ste. 102
Raleigh, NC 27607-3073

Thank you again for your interest. If you have any questions or need additional information, please feel free to contact N.C. Medicaid Provider Enrollment at the CSC EVC Center at 866-844-1113 or email the CSC EVC Center at NCMedicaid@csc.com.

For additional information, refer to the N.C. Medicaid Provider Enrollment web page – http://www.nctracks.nc.gov/provider/enrollment/index.html or the N.C. Division of Medical Assistance Home Page - http://www.ncdhhs.gov/dma.

Instructions for Enrolling to Provide Additional Community Alternatives Program Services with the N.C. Medicaid Program

The process for enrolling with N.C. Medicaid to provide additional Community Alternatives Program services includes the following steps:

1. Provider completes and signs the addendum packet and returns it along with the required credentials to:

For USPS Mail:	**For Certified/Overnight Mail Only:**
NC Medicaid Provider Enrollment	NC Medicaid Provider Enrollment
Attn: CSC EVC Center	Attn: CSC EVC Center
P.O. Box 300020	2610 Wycliff Road, Ste. 102
Raleigh, NC 27622-8020	Raleigh, NC 27607-3073

2. An addendum packet is considered to be invalid and must be returned to the provider for correction and/or for additional information if:
   - The version date on any of the documents that comprise the addendum packet is prior to January 2009.
   - The Contact Person's Name and Title is not completed.
   - The signatures, where required, are not original.
   - The signatures are not by the individual applicant or, where applicable, an authorized agent for the group or entity.
   - The text has been altered, highlighted, struck through, or obstructed through the use of correction fluids.
   - The responses are illegible.
   - The National Provider Identifier is not a valid number.
   - Any of the documents or pages that comprise the addendum packet is missing.
   - Any of the requested information in any of the documents that comprise the addendum packet is missing with the exception of the fax number and e-mail address.
   - Any of the required accreditation documentation is missing (including license, permit, certification, endorsement, Articles of Incorporation, NPPES letter, etc.).
   - The provider name entered on the addendum does not match the required accreditation documentation, your original Medicaid Participation Agreement, and the NPPES letter (where required).
3. Important Points to Remember
   - Copies of the applicable accreditation documentation must accompany the application. If these documents are missing, the application will be returned to the provider.
   - Retain a copy of your completed addendum packet and all documentation submitted with the enrollment packet for your records.
   - You will be notified by mail once your addendum packet has been approved. Please do not submit claims for any services until you have received notification of your approval and its effective date.
   - Billing information and clinical coverage polices are available on DMA's website at http://www.ncdhhs.gov/dma/prov.htm.

- Providers are responsible for notifying the CSC EVC Center when information related to their business or practice changes. Failure to report changes in a timely manner may result in suspension or termination of your Medicaid provider number and delay in your receipt of claims reimbursement. For guidance on reporting provider status change or to download the Medicaid Provider Change Form, refer to http://www.nctracks.nc.gov/provider/cis.html.
- Providers are requested to include on their application the name, e-mail address, and fax number of the individual (contact person) at their site who is responsible for receiving Medicaid information.

North Carolina Department of Health and Human Services
North Carolina Medicaid Provider Enrollment - 866-844-1113
Community Alternatives Program Services Addendum to Add Services

STATE/FISCAL AGENT USE ONLY
[ ] Initial Enrollment
[ ] Re-enrollment
[ ] CHOW

ADDENDUM TO NORTH CAROLINA PROVIDER PARTICIPATION AGREEMENT

This addendum shall become part of your participation agreement with the NC Medicaid Program. As an approved Medicaid Provider of Community Alternatives Program Services, I herby submit this Addendum to add the following services.

Current CAP Medicaid Provider Number: 34 ☐☐☐☐☐☐

1. Community Alternatives Program Services

Indicate the Community Alternatives Program Services your business/agency is adding:

A. CAP/DA (Disabled Adult) Services

- ☐ Adult Day Health Care
- ☐ Case Management
- ☐ Home Delivered Meals
- ☐ Home Mobility Aids
- ☐ In-Home Aide Level II
- ☐ In-Home Aide Level III Personal Care
- ☐ Medical Supplies
- ☐ Personal Emergency Response System (PERS)
- ☐ Respite Care – In-Home
- ☐ Respite Care – Institutional
- ☐ Waiver Supplies

B. CAP/C (Disabled Children/Katie Beckett) Services

- ☐ Case Management
- ☐ Home Mobility Aids
- ☐ Hourly Nursing
- ☐ Medical Supplies
- ☐ Personal Care
- ☐ Respite Care – In –Home (Aide)
- ☐ Respite Care – In-Home (Nursing)
- ☐ Respite Care – Institutional
- ☐ Waiver Supplies

C. CAP-MR/DD (Mentally Retarded/Developmentally Disabled) Services

- ☐ Adult Day Health Care
- ☐ Augmentative Communication Devices
- ☐ Crisis Respite
- ☐ Crisis Services
- ☐ Day Supports
- ☐ Home and Community Supports
- ☐ Home Modifications
- ☐ Home Supports
- ☐ Individual/Caregiver Training & Education
- ☐ Long-term Vocational Supports
- ☐ Personal Care Services
- ☐ Residential Supports
- ☐ Respite Care- Facility Based with 24 hrs awake staff
- ☐ Specialized Consultative Services
- ☐ Respite Care – Non-institutional Community Based
- ☐ Respite Care – Non-institutional Nursing-Based
- ☐ Respite Care – Institutional
- ☐ Specialized Equipment and Supplies
- ☐ Supported Employment
- ☐ Transportation
- ☐ Vehicle Adaptations
- ☐ Personal Emergency Response System (PERS)*
  *PERS does not require endorsement.

2. Organization Name:
Your organization name must match the organization name on your original Medicaid Participation Agreement and, as applicable, your current licensure or your current letter of endorsement.

_____

3. Doing Business As:
If applicable, enter your DBA name: _____

4. Physical Address:
Your physical address is the street address for the location where services will be rendered. A post office box address is not acceptable as a physical address.

_____
Street

_____ _____
City and State Zip Code + Four

5. County: _____

6. Accounting Address:
Your accounting address is the address where your Medicaid payment information (remittance advice) will be sent. If you leave this space blank, the remittance advice will be sent to your physical address.

_____
Street or Post Office Box

_____ _____
City and State Zip Code + Four

7. Telephone Number: (____) _____ – _____

8. Fax Number: (____) _____ – _____

9. E-mail Address: _____

10. Contact Person's Name: _____

11. Contact Person's Title: _____

12. Contact Person's Telephone Number: (____) _____ – _____

13. Provider Disclosure:

A. As required by 42 CFR 1002.3, providers must disclose the following information to the DMA or its agents. List all information requested for **each person, including yourself, who has direct or indirect ownership or control interest of 5% or more in the organization/entity.** If any of the persons named are related to each other as parent, spouse, child or sibling, indicate the relationship. Failure to provide sufficient information, including complete Social Security Numbers, to allow for the verification of the disclosed information may result in a denial for participation with the N.C. Medicaid Program.

Full Name (First Name, MI, Last Name) and Complete Address (Street, City, State & Zip Code)	Title (if applicable)	Social Security Number	% Ownership
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner ☐ Officer ☐ Managing Employee ☐ Director ☐ Board Member ☐ Other ______________________ ☐ Electronic Funds Transfer (EFT) authorized individual		
Check relationship to other persons named: (Check all that apply)	☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None ☐ Other __________________________		

Full Name (First Name, MI, Last Name) and Complete Address (Street, City, State & Zip Code)	Title (if applicable)	Social Security Number	% Ownership
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner ☐ Officer ☐ Managing Employee ☐ Director ☐ Board Member ☐ Other ______________________ ☐ Electronic Funds Transfer (EFT) authorized individual		
Check relationship to other persons named: (Check all that apply)	☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None ☐ Other __________________________		

Full Name (First Name, MI, Last Name) and Complete Address (Street, City, State & Zip Code)	Title (if applicable)	Social Security Number	% Ownership
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner ☐ Officer ☐ Managing Employee ☐ Director ☐ Board Member ☐ Other ______________________ ☐ Electronic Funds Transfer (EFT) authorized individual		
Check relationship to other persons named: (Check all that apply)	☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None ☐ Other __________________________		

B. As required by 42 CFR 1002.3, providers must disclose the following information to the DMA or its agents. List all information requested for **each agent of the organization/entity including individual officers, directors, managing employees (general manager, business manager, administrator), and Electronic Funds Transfer (EFT) authorized individuals.** If any of the persons named are related to each other as parent, spouse, child or sibling, indicate the relationship. Failure to provide sufficient information, including complete Social Security Numbers, to allow for the verification of the disclosed information may result in a denial for participation with the N.C. Medicaid Program.

<table>
<tr><th>Full Name (First Name, MI, Last Name)
and Complete Address
(Street, City, State & Zip Code)</th><th>Title
(if applicable)</th><th>Social Security Number</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="2" rowspan="2">Check business relationship that applies:
☐ Owner
☐ Shareholder ☐ Partner ☐ Officer
☐ Managing Employee ☐ Director ☐ Board Member
☐ Electronic Funds Transfer (EFT) Authorized Individual
☐ Other ____________________</td></tr>
<tr><td></td></tr>
<tr><td colspan="3">Check relationship to other persons named: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ None
(Check all that apply) ☐ Other ________________________</td></tr>
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(Check all that apply) ☐ Other ________________________</td></tr>
</table>

14. **Disciplinary Actions** (You must answer all sections [A through K] of this question):

Have you or any of the individuals or entities listed in Questions 13.A and 13.B ever:

A. Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or entered into a pre-trial agreement for a felony?

Yes ☐ No ☐

If Yes, list the name(s) of the individual(s) and you must attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.

_____

_____

B. Had any disciplinary action ever been taken against any business or professional license held in this or any other state? Or has your license to practice ever been restricted, reduced or revoked in this or any other state? Or been previously found by a licensing, certifying or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided? Or entered into a Consent Order issued by a licensing, certifying or professional standards board or agency?

Yes ☐ No ☐

If Yes:

Against Whom? _____

Action Taken? _____

Who Took Action? _____

Date of Action? _____

If Yes, you must attach a complete copy of the Consent Order and or final disposition. You must also attach documentation from the proper authorities approving the reinstatement of the license.

C. Been denied enrollment, been suspended, excluded, terminated or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state, or been employed by a corporation, business, or professional association that has ever been suspended, excluded, terminated or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state?

Yes ☐ No ☐

If Yes, you must list the name(s) and provider number(s) of the individual(s) or entity(ies) and attach a complete copy of applicable documentation.

Name	Provider Number

D. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state?

Yes ☐ No ☐

If Yes, you must list the name(s) and provider number(s) of the individual(s) or entity(ies) and attach a complete copy of applicable documentation.

Name	Provider Number

E. Had civil monetary penalties levied against this organization/entity or any individuals or entities listed in Questions 1 and 2 by Medicare, Medicaid or other State or Federal Agency or Program, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full?

Yes ☐ No ☐

If Yes, you must attach an explanation and supporting documentation from the agency or program which levied the penalties as to the reason.

F. Owe money to Medicare or Medicaid that has not been paid?

Yes ☐ No ☐

G. Been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services?

Yes ☐ No ☐

If Yes, list the name(s) of the individual(s) and you must attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.

H. Been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?

Yes ☐ No ☐

If Yes, list the name(s) of the individual(s) and you must attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.

I. Been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct?

Yes ☐ No ☐

If Yes, list the name(s) of the individual(s) and you must attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.

J. Been found to have violated federal or state laws, rules or regulations governing North Carolina's Medicaid program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program and been sanctioned accordingly?

Yes ☐ No ☐

If Yes, you must list the name(s) and provider number(s) of the individual(s) or entity(ies) and attach a complete copy of applicable documentation.

Name	Provider Number

K. Been convicted of an offense against the law other than a minor traffic violation?

Yes ☐ No ☐

If Yes, list the name(s) of the individual(s) and you must attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.

15. Is the organization/agency incorporated?

Yes ☐ No ☐

If Yes, please attach a complete copy of the Certified Articles of Incorporation or Articles of Organization and any subsequent changes to the Articles of Incorporation or Articles of Organization.

16. Certification Statement:

The Undersigned certified the following:

a. Provider attests that the contents of this application are true, accurate, and complete.
b. There has been no:
   i. Change in ownership
   ii. Site, location or agency
   iii. Tax reporting or agency
c. Provider understands that some changes may require additional information or a new application process.
d. All information on file with the CSC EVC Center is current and correct.
e. I agree to abide by the laws, regulations and program guidelines applicable to the services I have hereby applied to render.
f. Provider certifies that they meet the qualifications and standards defined in the services definitions for the services herein requested.
g. Providers agrees to provide such services within the guidelines of the most current service definitions(s) approved by the Division of Medical Assistance.

17. Consent to Release Information:

I understand that the North Carolina Division of Medical Assistance (DMA) and its representatives is responsible for the evaluation of my professional training, experience, professional conduct, and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief.

I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Medicaid Program. I understand and agree that as an applicant for participation in the Medicaid Program, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize DMA and its representatives to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between DMA and its representatives and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by DMA and its representatives to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Program and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions acting in good faith and without malice for acts performed in gathering or exchanging information in this credentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Program’s credentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or DMA to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

Signature of Authorization Required:

****Information Must Be Entered For The Agreement To Be Processed****

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual agreements must have the provider's original signature. Authorized agents can only sign for group agreements.

_____

Signature of Applicant or Authorized Agent **Date**

_____

Printed Name and Title

INTERNAL USE BY THE DIVISION OF MEDICAL ASSISTANCE OR FISCAL AGENT

EFFECTIVE DATE:

This agreement is executed and shall become effective on the _____ day of _____ in the year of _____.

The agreement shall remain subject to renewal on a periodic basis. A new agreement may be required as DMA necessitates, by operation of law, Medicaid regulations, polices or other material circumstances, or termination upon substitution of a new agreement, or by act of the parties as herein provided. You are herein authorized to provider services of which are in accordance with the approved services definitions.

DMA/FISCAL AGENT APPROVAL:
Accepted on _____ by _____

Attachment C

LETTER OF ATTESTATION

The Deficit Reduction Act (DRA) of 2005, which went into effect January 1, 2007, required specific changes to states' Medicaid programs. One of the changes is the requirement for employee education about false claims recovery. Section 6032 of the DRA amended the Social Security Act, Title 42, United States Code, Section 1396(a) by inserting an additional relevant paragraph (68). This paragraph is cited below; in summary it requires any entities that receive or make annual payment under the Medicaid State Plan of at least five million dollars to have detailed, specific written policies established about the Federal and State False Claims Acts for their employees, agents and contractors.

Specifically, §1396(a)(68) of the Social Security Act requires that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall –

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under section 3729 through 3733 of title 31, United States Code [31 USCS §3729-3733], administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code [31 USCS §. 3801 et seq.], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)[42 USCS § 1320-7b(f)]);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

Effective January 1, 2007, all providers who meet the above conditions are required to certify that they are in compliance with §1396(a)(68) of the Social Security Act as a condition of enrollment in the North Carolina Medicaid Program.

As a North Carolina Medicaid provider, or the owner/ operator/ manager of a North Carolina Medicaid provider entity, I certify that our entity has read and understands the above requirements. I also certify that if our entity receives or makes annual payments under the State plan of at least $5,000,000 we have complied with and established written policies and procedures that provide detailed information concerning the Federal False Claims Act, 31 USC 3729 *et seq.,* administrative remedies for false claims and statements established under 31 USCS §. 3801 *et seq.,* and any North Carolina State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.

I further certify, when the above conditions apply, that our entity's written policies include detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse; and that our employee handbook contains a specific discussion of the Federal and State False Claims Acts, the rights of the employees to be protected as whistleblowers, and our policies and procedures for detecting and preventing fraud, waste, and abuse.

Copies of any and all training manuals, written policies and procedures for detecting and preventing fraud, waste, and abuse, and employee handbooks will be maintained on-site for a minimum of five (5) years for inspection and auditing by the Division of Medical Assistance

Medicaid Provider Name: _____

(must match name on Medicaid Participation Agreement)

Business Site/Physical Address:

_____

Street

_____

City & State **Zip Code + Four (Last 4 digits required)**

Signature Authorizations and Related Information Required

**** All Information Must Be Entered for the Application to be Processed****

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

_____

Signature of Applicant or Authorized Agent **Date**

_____

Printed Name and Title